TOTAL HEALTH PROGRAM: *BASELINE* PHYSICAL HEALTH INDICATORS FORM

INSTRUCTIONS TO RN Care Managers*: The overall goal of tracking health indicators is to improve the health outcomes of THP participants, over time, via screening and subsequent intervention.* ***Please print all requested information****.*

Section I: Participant Information & Referrals *[See Physical Health Screening Form for Provider and Insurance information.]*

Clinic Site:	Date of Baseline Screening (*MM/DD/YY*): / /
Participant Name (*Last, First*):	RN Care Manager:
Participant Phone:	CLIENT #:
DOB (*MM/DD/YY*): / /	Sex: [ ] Male [ ] Female
PHC Provider Name: Date Last Seen **Prior to THP** Referral (*MM/DD/YY*): / / Date Last Seen **Since THP** Referral (*MM/DD/YY*): / /	Health Insurance: [ ] Medicaid [ ] Medicare [ ] None [ ] Other (*please specify)*:
Name of Dentist: Date Last Seen and Reason:	Are You Having Any Dental Problems? **[ ] Yes [ ] No** If Yes, Please Explain:
Was Participant Referred to a Provider or Any Service? (Check one box) **[ ] Yes** - Please complete a *Referral Follow-Up Sheet* **[ ] No** - Comments: **Wellness Referrals (**√ all that apply**)** **[ ] Tobacco [ ] Nutrition [ ] Fitness**	

Section II: Housing & Transportation

Is your housing situation stable? **[ ] Yes [ ] No** Comments:
Do you have reliable transportation? **[ ] Yes [ ] No** Comments:
Who was present at interview?
Does participant demonstrate any impairment in verbal communication or mobility? **[ ] Yes [ ] No** Comments:

Please Record CLIENT #_____

Section III: Health Indicators & Reassessment Dates *[Record health indicator data in appropriate space. Evaluators will convert height, weight, and waist circumference. Record baseline screening date and **all** 3-month reassessment dates in last 2 columns (MM/DD/YY).*

Health Indicators				**Screening and Reassessment Dates**	
See Health Data Monitoring Form				***Baseline*** / /	***24 mos.*** / /
Blood Pressure S		Did client fast 8 hours prior?	**Y N**	***3 mos.*** / /	***27 mos.*** / /
Blood Pressure D		Date Labs Drawn	/ /	***6 mos.*** / /	***30 mos.*** / /
Weight	_____=	Blood Glucose / HgBA1C		***9 mos.*** / /	***33 mos.*** / /
Height	_____=	Lipid Total (Tot. Chol.)		***12 mos.*** / /	***36 mos.*** / /
Waist Circumference	_____=	Lipid HDL		***15 mos.*** / /	***39 mos.*** / /
BMI		Lipid LDL		***18 mos.*** / /	***42 mos.*** / /
Breath CO ppm		Lipid TRI			
Notes:					

Section IV: Personal and Family Medical and Substance Use History *[Please check the appropriate box.]*

Personal Medical History "Do you have . . ."		**Family Medical History "Does anyone in your family have …"**	
Diabetes	[ ] Yes [ ] No [ ] Don't Know	Diabetes	[ ] Yes [ ] No [ ] Don't Know
High blood pressure	[ ] Yes [ ] No [ ] Don't Know	High blood pressure	[ ] Yes [ ] No [ ] Don't Know
Cardiac/heart problems	[ ] Yes [ ] No [ ] Don't Know	Cardiac/heart problems	[ ] Yes [ ] No [ ] Don't Know
Cancer	[ ] Yes [ ] No [ ] Don't Know	Cancer	[ ] Yes [ ] No [ ] Don't Know
Personal Substance Use History "Do you . . ."		**Family Substance Use History "Does anyone in your family …"**	
Drink beer, wine, or alcohol	[ ] Yes [ ] No [ ] Refused	Drink beer, wine, or alcohol	[ ] Yes [ ] No [ ] DK/Refused
Smoke or chew tobacco	[ ] Yes [ ] No [ ] Refused	Smoke or chew tobacco	[ ] Yes [ ] No [ ] DK/Refused
Use non-prescribed drugs	[ ] Yes [ ] No [ ] Refused	Use non-prescribed drugs	[ ] Yes [ ] No [ ] DK/Refused

Section V. Medication History *[Please list the names of all medications ever used that participant can recall.]*

Please Record CLIENT #_____

Section VI: Current Medication List *[Please list or attach list of current medications used by participant within the last 30 days, including medications for pain. Please identify dose and prescribing doctor for each medication. Ask participant to bring bottles each visit.]*

Medication	Dose	Prescribing Doctor
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Section VII: Diagnoses: Substance Use and Mental Disorders & Primary Health Care: *[Please list diagnoses for substance use, mental disorders, and primary health care problems.]*

Substance Use Disorder DX (Leave blank if none):
Primary Mental Disorder DX: *For Catherine:* [ ]
Primary Health Care DX (Please list all):

Section VIII: LOCUS/IV Recovery Environment *[Please record LOCUS/IV Recovery Environment Level of Stress and Level of Support Dimension Scores (Range = 1-5). See last page of Progressive Assessment in client's CAHSD record.]*

LOCUS/IV Recovery Environment Level of Stress: [ ]
LOCUS/IV Recovery Environment Level of Support: [ ]

INSTRUCTIONS TO RN CARE MANAGERS: *File **Baseline form** and **Referral Follow-Up Sheet** in client's THP chart.*
Contact Catherine Lemieux if you have any questions (578-1018, clemieu@lsu.edu)